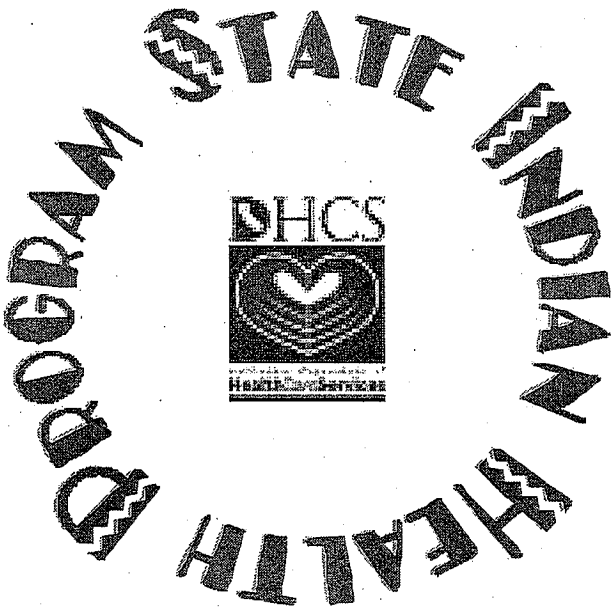
INDIAN HEALTH PROGRAM

INFORMATION UPDATE REQUEST
FISCAL YEAR (FY) 2009-2010



Primary and Rural Health Division (PRHD)
California Department of Health Care Services (DHCS)

April 2009

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IMPORTANT DATES

Information Update documents sent to grantees: April 10, 2009

Application due: May 11, 2009

Grant period begins: July 1, 2009

Grant period ends: June 30, 2010

Part I

PROGRAM INFORMATION

INDIAN HEALTH PROGRAM (IHP)

Information Update Request
Fiscal Year (FY) 2009-2010

PART I
PROGRAM INFORMATION

Purpose

The purpose of this Information Update Request (information update) is to obtain information necessary to amend the grants of currently funded agencies to include FY 2009-2010 funding and Scope of Work (SOW) activity.

Funding

Funding amounts are determined annually based on the Indian Health Program (IHP) clinic allocation formula (See Exhibit 2). Note that funding is subject to the final appropriation in the State Budget Act of 2009.

Legislative Authority

The IHP is authorized by California Health and Safety Code, Sections 124575 -124595. The goal of the IHP is to improve the health status of American Indians residing in California.

Fiscal Year (FY) 2009-2010 Award

Notification of IHP grantee award amounts for FY 2009-2010 is scheduled for May 4, 2009. Grantees will be notified via FAX and letter.

Funding Limitations

IHP funding alone will not be adequate to sustain a health program. Funds appropriated to carry out the purpose of this information update shall be supplemental to those available from the federal government and shall not duplicate, or replace, any commitments made by the federal government to provide health services to American Indians and their families in this state who receive health services pursuant to an urban or rural American Indian health program, per Health and Safety Code Section 124585. Thus, all applicants must demonstrate reliance on multiple funding sources.

IHP Eligibility Requirements

To be eligible for funding, an Indian health program shall be administered by either a non-profit corporation organized under the laws of this State or by an Indian Tribe. The board of directors or trustees of such corporation shall be composed of a majority of Indians. (California Code of Regulations, Title 17, Section 1534).

"Indian Tribe" means any Indian Tribe, band, or nation or other organized group or community which is determined to be

eligible for the special programs and services provided by the United States or State of California to Indians because of their status as Indians (California Code of Regulations, Title 17, Section 1501, Chapter 3.1)

Program Funding Qualifications

To qualify and retain funding, grantees shall demonstrate at the time of application and throughout the term of the grant, the following specific requirements and all other requirements set forth in the FY 2006-2007 RFA:

1. Good standing with the Office of the Secretary of State and the Office of the Attorney General (if a non-profit corporation),
2. Good standing with the Bureau of Indian Affairs (if an Indian Tribe),
3. Board of Directors that is comprised of a majority of American Indians, represents the local American Indian community, and functions according to its bylaws,
4. State clinic licensure (or exemption) for all clinic sites,
5. A clinic pharmacy permit (if applicable),
6. Provision of at least two of the following three services – medical, dental, and/or community health services – with each service to be provided at least 24 hours per week in FY 2009-2010,
7. Clinical Laboratory Improvement Act (CLIA) state registration (if applicable),
8. Liability and malpractice insurance in sufficient amounts to meet current state requirements of not less than $1,000,000 per occurrence for bodily injury and property damage liability combined or Torts claims coverage.

Required Components of Indian Health Clinics

The following are required components of Indian Health Clinics: Administration, Traditional Indian Health (TIH), and Direct Health Services. These requirements are included in the IHP guidelines for grantees. The guideline documents: Board, Administration, and Fiscal; Medical; Dental; and Community Health Services are available at the IHP website at:
www.dhcs.ca.gov/services/rural/Pages/ IndianHealthProgram.aspx

Scope of Work

IHP grantee scopes of work for medical, dental, and community health services are determined through the application of the IHP Provider Productivity Formula (See Exhibit 1). The Provider Productivity Formula is based on the Estimated Staffing Pattern (ESP) for Fiscal Year 2009-2010

that was submitted in April 2009. Therefore, a separate SOW is not required to be submitted in this application.

Grantee General Requirements

1. Comply with all provisions of the grant agreement including, but not limited to, provisions of the quality and quantity of the direct and subcontracted services specified to the population(s) targeted,
2. Provide services in a culturally competent manner,
3. Assure that community members and/or clients participate in the development of policies and procedures on an ongoing basis through their governing Board of Directors,
4. Comply with all governmental laws and regulations appropriate to the operation of a primary care health clinic program and ensure all subcontractors also comply.

Grantee Program Requirements

Grantees shall maintain throughout the term of the grant agreement the following requirements:

1. Notify the IHP within 72 hours regarding any situation that would substantially alter the grantee's ability to comply with grant obligations,
2. Participate in relevant evaluation and monitoring activities as determined by the State to identify levels of grant compliance and need for consultation/technical assistance,
3. Participate in program evaluation activities such as surveys or questionnaires,
4. Participate in technical assistance activities identified as needed by the state including, but not limited to, workshops, conferences, individual assistance, etc.
5. Carry out the provisions of the grant and ensure that all subcontractors carry out the provisions of the grant in the most cost-effective and cost-efficient manner possible,
6. Provide services consistent with the current version of the four IHP guideline documents: Board, Administration, and Fiscal; Medical; Dental; and Community Health Services. These documents are available at the IHP website at: www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx

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Advance Payments

1. The grantee may request an Advance Payment in compliance with Health and Safety Code Section 124525.

2. An advance payment equal to not more than 25 percent of the total grant award shall be made to the grantee at the time that the notice of award is issued, subject to the following conditions:

    a. Such payments shall be made only to the extent funds are available,
    b. Grantee is a non-profit agency,
    c. Department has evaluated the financial stability of the clinic and found it to be reasonably financially sound,
    d. Advance payments be made only to those nonprofit agencies that request an advance in writing, as further described below,
    e. Application or proposal contains the terms and conditions set forth in the request for application or the request for proposal,
    f. Application or proposal is signed by an authorized person representing the clinic,
    g. Amount of the advance payment will be fully liquidated from subsequent grant payments,
    h. If the grant is not fully executed, the grantee shall repay the full amount of any outstanding advance.

Prospective Payments

Grantees shall receive two semiannual prospective payments during a 12-month grant award year provided that the following conditions are met. These payments are contingent upon the State's receipt and approval of satisfactory performance of the SOW and budgeted expenditures. Listed below is the payment schedule and required documents to be submitted before payment can be approved:

1. A first prospective payment equal to not more than 50 percent of the total grant award shall be processed for payment to the grantee upon enactment of the Budget Act, subject to the following conditions:

    a. Availability of funds,
    b. Formal execution of the grant by the state,
    c. Submission by the grantee of a written request for payment,
    d. If the grantee was the recipient of a grant for the prior year, grantee's timely and accurate submission, and the department's approval, of the progress reports required under the grant, budget

Prospective Payments Continued

expenditure report, and annual reconciliation report, from the prior year,

e. The amount of the advance payment will be fully liquidated from subsequent grant payments.

2. A second prospective payment equal to not more than 40 percent of the total grant award shall be processed for payment to the grantee no earlier than January 1 of the grant year, subject to the following conditions:

   a. Submission by the grantee of a written request for payment, as described below,
   b. Grantee's timely and accurate submission, and the department's approval, of the progress reports required under the grant and the Budget Expenditure Reports for July through December of the fiscal year. Grantee's satisfactory performance under the grant.

3. Any remaining amount, which shall be at least 10 percent of the total annual grant award, shall be retained by the Department pending:

   a. Submission by the grantee of a written request for payment, as described below,
   b. Grantee's timely and accurate submission, and the department's approval, of the progress reports required under the grant and the Budget Expenditure Report for January through April of the fiscal year, the Annual Reconciliation Report, and satisfactory performance under the grant.

Part II

INFORMATION UPDATE INSTRUCTIONS

INDIAN HEALTH PROGRAM (IHP)

Information Update Request
Fiscal Year (FY) 2009-2010

PART II
INSTRUCTIONS

General Instructions

Be sure to include all of the information required in the information update, including all attachments.

Format

Applicants must return the following material according to the format and instructions stated herein. Failure to follow these format instructions or failure to return the required forms and materials may deem an application non-responsive and may cause that application to be eliminated from further consideration.

The information update may not be submitted in a binder or folder; these are too cumbersome for distribution and review. Use a staple, binder clip, or other means to bind your application.

1. Number the pages of the information update sequentially from page 1 to the end of the application, including title pages and attachments at the bottom center of each page,
2. Include the name of the applicant on each page on the top left,
3. Put all section headings flush left in bold type,
4. The format of the application should allow at least one-inch margins at top, bottom, and sides,
5. The type font size is to be no less than 12 points,
6. The application should be single-spaced unless otherwise instructed in this document.

Signatures

All forms and attachments, that require signatures, must be signed in blue ink for inclusion in the original application package, unless noted otherwise. Signature stamps are not acceptable. The additional application set may reflect photocopied signatures.

Information Update Submission

Information updates must be completed according to the instructions. Incomplete or late information updates may not be accepted. DHCS reserves the right to reject any or all information updates, issue a new information update, as well as to make the final selection of applicants for funding.

Do not submit any materials that are not requested. Any materials submitted (including letters of support) that are not part of the information update requirements will be discarded upon receipt.

The same subcontractor(s) may be proposed for use by more than one applicant. An entity submitting an application as a prime contractor may also be identified as a subcontractor in another firm's application.

Information Update Deadline

Regardless of postmark or method of delivery, the IHP must receive an original information update package and one (1) copy on or before 5:00 p.m., **May 11, 2009**. The package can be delivered or mailed. Faxed and electronically mailed documents will not be accepted.

The information update must be received by mail or in person by 5:00 p.m. on May 11, 2009 at the following address:

Mailed via United States Postal Service (USPS)

California Department of Health Care Services
Indian Health Program
PO Box 997413
MS 8502
Sacramento, CA 95899-7413
Attn: Andrea Zubiate, Coordinator

Hand-carried or Overnight Delivery

California Department of Health Care Services
Indian Health Program
MS 8502
1501 Capitol Avenue, Suite 71.6044
Sacramento, CA 95814-7413
916-449-5760
Attn: Andrea Zubiate, Coordinator

Submission Requirements

A complete information update must include the following list of forms and supplemental information in this order:

Forms A-J

1. Information Update Checklist/Table of Contents (Attachment A)
2. Information Update Cover Sheet (Attachment B)
3. Clinic Site Information Form (Attachment C)
4. Medi-Cal Provider Status Form (Attachment D)
5. Licensed Personnel Information Form (Attachment E)
6. Program Narrative Form (Attachment F)
7. Certification of Terms and Conditions of Advance Payment (Attachment G)
8. Authorization to Bind Corporation and Payment Request Approval Form(Attachment H)
9. List of all current Board members (Attachment I)
10. All application budget pages (Attachment J)
    a. Table 1—Summary of Current Budget from All Sources
    b. Table 2—Current Personnel Line Item Budget from All Sources
    c. Table 3—Total Clinic Projected Revenues and Expenses
    d. Table 4—Proposed IHP Budget

Supplemental Information

1. Clinic's license or certification number with expiration date, pharmacy permit/certificate (if applicable), Clinical Laboratory Improvement Act (CLIA) certificate or a waiver (if applicable) with expiration dates,
2. Corporate By Laws sent to the Registry of Charitable Trusts, Office of the Attorney General, State of California, and/or Tribal Charter,
3. Tax forms including the most recent Federal F-990 and State F-199 and CT2 forms or extension requests. Tribal programs that are exempt from these filings must submit copies of federal and state documents so indicating these exemptions,
4. Job descriptions for all personnel proposed for funding by the IHP,
5. Organizational chart (identify vacancies),
6. Evidence of liability, medical and/or dental malpractice insurance or certification of Torts claims coverage,
7. California Charitable Trust Form RRF-1, if exempt please indicate and include supporting tribal documentation,
8. The program's most current monthly or quarterly financial statement that includes all corporate debts and incoming funds for the program.

PART II
INSTRUCTIONS FOR COMPLETING INFORMATION UPDATE FORMS
(Attachments A— J)

Attachment A

Information Update Checklist/Table of Contents
The information update response must be submitted in the order presented in the Information Update Checklist (Page 20). Indicate page number in your application. Include the applicable items and reference the appropriate page number in your information update. If an item is not applicable indicate "N/A".

Attachment B

Information Update Cover Sheet
Complete all items listed on the information update cover sheet. The information update will be returned unprocessed if the original signatures of the Board Chairperson, Program Administrator, and Fiscal Officer are missing. If any of these positions are currently vacant, the board must authorize in writing an acting individual to perform the functions of the vacant position (please attach copy of authorization).

Attachment C

Clinic Site Information Form
Complete all information for main clinic site and all satellites. List the names of reservations and Rancherias in the service area and indicate contracting status. Include additional pages if needed.

Attachment D

Medi-Cal Provider Status Form
Provide Medi-Cal, Denti-Cal and National Provider Identifier (NPI) billing information including clinic provider and individual provider numbers (provider's license must be current) and all corresponding service site numbers and provider names. Also required is a copy of an agreement that states that income derived from billing under the provider's number is the clinic's income (if applicable).

Attachment E	**Licensed Personnel Information Form** List all licensed health personnel including, type of license, license number, and expiration date. All licenses must be current on the date of submission.
Attachment F	**Program Narrative Form** Include a program narrative that addresses the items listed.
Attachment G	**Certification of Terms and Conditions of Advance Payment** In submitting the application, applicant is certifying awareness of the Terms and Conditions for approval of Advance Payment. Have authorized individuals sign the document in **blue ink**.
Attachment H	**Authorization to Bind Corporation and Payment Request Approval Form** The Authorization to Bind Corporation and Payment Request Approval Form authorizes representatives of the clinic to negotiate and sign an IHP grant and payment request. At least two persons must be authorized to sign payment requests. Complete all information requested on the form and have authorized individuals sign the document in **blue ink**.
Attachment I	**Board of Directors Information Form** Complete information for all members of the Board of Directors. Use additional pages if necessary.
Attachment J	**Budget Instructions (Tables 1-4)**
Table 1	**Summary of Current Budget from All Sources** List ***all*** funding sources, including Medi-Cal and other Third Party Revenues. List separately the subtotals for Personnel, Operating Expenses, and Consultants.
Table 2	**Current Personnel Line Item Budget from All Sources** List the current personnel line item budget from all funding sources. List separately the source of funds for each staff member.

Table 3

Total Clinic Project Revenues and Expenses
List projected clinic revenues and expenses for FY 2009-2010

Table 4

Proposed IHP Budget FY 2009-2010
Submit a five line item budget consisting of the following line items: Personnel, Operating, Capital Expenditures, Other Costs, and Indirect Costs. Round all amounts to whole dollars. Check budget table for accuracy. The horizontal and vertical grant totals must agree.

Instructions for Completing Table 4

Unreimbursable Expenses

Expenses not reimbursed by the DHCS include the following:

1. Purchase, renovation, alteration, or improvement of contractor owned or leased property (real estate) or facilities.
2. Contract care as defined by Federal Indian Health Services Regulations.

Personnel

List position title rather than the name of the individual. Please include job descriptions for ***all*** IHP funded positions.

1. **Column A**: The "FTE Salary Per Pay Period". Full-time Equivalent (FTE) is the rate of pay an individual would earn if their time base was 100%. The figure entered in this column can be determined by calculating the annual amount the individual would earn as an FTE, and then by dividing this annual amount by the number of pay periods during the grant period,
2. **Column B**: Indicate the "Number of Pay Periods" for the period July 1, 2009 to June 30, 2010, e.g., 12, 24, 26,
3. **Column C**: The "Percent of FTE" worked by the individual is based on a 40-hour workweek. This is the total time the individual works at your program regardless of funding source (see below),

Hours Per Week	Percent of FTE	Hours Per Week	Percent of FTE
4	10	24	60
8	20	28	70
12	30	32	80
16	40	36	90
20	50	40	100

Personnel continued

4. **Column D**: The "Percent Paid by This Grant". Indicate the percent of annual salary that will be paid by this grant,

5. **Column E**: The "Amount Requested". Multiply A x B x C x D to determine E,

6. **Fringe Benefits** – Indicate the percentage of Personnel Costs used to calculate fringe benefits. List fringe benefits (i.e. Federal Insurance Contributions Act (FICA), State Unemployment Insurance (SUI), Workers Compensation (WC)). If the "fringe benefit" rate is above 30 percent, please provide justification.

Operating Expenses

The following are allowable operating expenses:

Audit	Audits carried out pursuant to Health and Safety Code, Sections 38040 and 38041 shall be audits of the grantee, rather than audits of individual grants or programs. Audits shall be in accordance with Federal Office of Management and Budgets (OMB) Circular A-133 "Single Act Audits" for contractor receiving $500,000 or more of federal dollars. The cost of such audit may be included in direct service contracts up to the proportionate amount that the contract represents of the contractor's total revenue (e.g., if total funds are $1,000,000 of which state funds represents $100,000, the contractor may budget 1/10 of the $100,000 amount or $10,000 in the state budget because $100,000 is 1/10 of $1,000,000).
Communications	Telephone, postage, advertising, and answering service.
General Expense	Purchase of books, magazines, publications, and subscriptions; expendable office supplies; shipping costs; professional memberships and dues; expendable equipment (less than $5,000 and/or having a life expectancy of less than one year); equipment maintenance, rental, and repair; installation costs; printing expenses; pre-employment physicals.
Insurance	All insurance including liability and malpractice.
Janitorial/Maintenance Services	Housekeeping and cleaning services, water cooler, copy machine maintenance (does not include rent), routine minor repairs for electrical, plumbing, or building facilities.

Operating Expenses Continued

Patient Transportation	Expendable vehicle expenses (gasoline and oil) incidental to the transportation of clinic patients for program-related business.
Rent	List number of square feet, cost per square foot, cost per month, and percentage of state share.
Technical Supplies	Expendable medical, laboratory, X-ray, and pharmaceutical supplies that are less than $5,000 and/or have a life expectancy of less than one year.
Traditional Health / Medicine	Travel and related costs for Native healers, doctoring, traditional Indian health gatherings, and educational and cultural sensitization activities for agency personnel.
Travel	Travel and per diem must be consistent with state travel guidelines found at http://sam.dgs.ca.gov - State Administrative Manual and may not exceed state rate.
Utilities	Electricity, gas, water, sewer, and garbage service.
Vehicle Operation and Maintenance	Minor and major vehicle repair and maintenance, tires, batteries, license fees, and registration.
Capital Expenditures	Equipment expenses for individual items valued at $5,000 or more with a life expectancy of one year or more. Include the unit cost of each item and the total cost (number of units multiplied by the unit cost, plus tax). Equipment is subject to State inventory tracking requirements.

Other Costs

Consulting and Professional Services	Grant-related services performed by "independent contractors" as defined by Title 22, Division 2.5, Section 4304.1 (Employment Development Department) who are not employees of the grantee. Fees for administrative, medical, and/or dental consultation or referral services such as laboratory and x-ray. List each consultant, the rate of dollars per hour, and the total subcontract amount.
Staff Training and Continuing Education	May include tuition, registration, and material for continuing education classes, books/periodicals related to employee job duties, or health-related information only. May include expenses related to seminars, meetings, and conferences if related to program activities.

Indirect Costs

Expenses incurred for the benefit of the business as a whole and which cannot be readily identified with the activities of a given department/program. The IHP relies on indirect cost pool and rate computations approved by the federal government in order to evaluate the appropriateness of the costs applicants include in their proposed IHP budgets. Tribal applicants for IHP funds may submit an "Indian Organizations Indirect Cost Negotiation Agreement" form that is also available online at http://www.nbc.gov/icshome.html, which is the website maintained by Indirect Cost Services, National Business Center of the U.S. Department of Interior. Other applicants may submit a "Nonprofit Rate Agreement" form that can be obtained on-line at http://rates.psc.gov, the website run by the Division of Cost Allocation, Financial Management Service, Program Support Center of the U.S. Department of Health and Human Services. **A copy of the appropriate "indirect cost" document must be submitted.**

Total Percent of IHP Budget

Please indicate the percent of IHP budget used towards the expenses of the main clinic site.

Attachments A-J

ATTACHMENT A, page 20

Information Update Checklist/Table of Contents

Your application should be in the order presented below. The following documents must be attached to this application. Please indicate page number in your application or if the item is not applicable.	Page # (or N/A)
1. Information Update Checklist – Table of Contents (Attachment A)	
2. Information Update Cover Sheet (Attachment B)	
3. Clinic Site Information Form (Attachment C)	
4. Medi-Cal Provider Status Form (Attachment D)	
5. Licensed Personnel Information Form (Attachment E)	
6. Program Narrative Form (Attachment F)	
7. Certification of Terms and Conditions of Advance Payment (Attachment G)	
8. Authorization to Bind Corporation and Payment Approval Request Form (Attachment H)	
9. Board of Directors Information Form (Attachment I)	
10. Table 1 – Summary of Current Budget from All Sources (Attachment J)	
11. Table 2 – Current Personnel Line Item Budget from All Sources (Attachment J)	
12. Table 3 – Proposed IHP Budget (Attachment J)	
13. Table 4 – Total Clinic Projected Revenues and Expenses (Attachment J)	
14. The most recent quarterly or monthly financial statement that includes all corporate debts and incoming funds for the program.	
15. Copy of all of clinic's current license(s) and/or certification(s)	
16. Copy of pharmacy permit or license, if applicable	
17. Copy of CLIA certificate, if applicable	
18. Current Federal IRS Form 990, California State FTB Form 199, or a Request for an Extension for filing (Federal form 2758 and State form 3504). If you are a tribe and exempt from taxation a copy of the documents submitted to Federal and State tax offices.	
19. Job descriptions for all personnel proposed for funding by the IHP	
20. Copy of organizational chart (identify personnel vacancies)	
21. Current evidence of liability, medical and/or dental malpractice insurance or Torts claims coverage.	
22. Current California Charitable Trust Form RRF-1, if exempt please indicate and include supporting tribal documentation.	
23. If billing under physician(s)/dentist(s) provider number, a written agreement that any income derived from billing under the physician(s)/dentist(s) provider number is clinic income.	
24. Copy of current Corporate By Laws sent to the Registry of Charitable Trusts, Office of the Attorney General, State of California, and/or Tribal Charter	
25. Recent independent Certified Public Audit.	
26. Copy of the appropriate "indirect cost" document.	

State of California – Health and Human Services Agency
Department of Health Care Services

Primary and Rural Health Division
Indian Health Program

Indian Health Program (IHP)
Information Update Cover Sheet
Fiscal Year 2009-2010

LEGAL CORPORATE NAME (APPLICANT):	
MAILING ADDRESS:	ZIP CODE:
LOCATION (If different from mailing address):	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:
CORPORATE FISCAL YEAR DATES:	ANTICIPATED DATE OF NEXT FISCAL AUDIT:
MEDICAID / MEDICARE PROVIDER TYPE (select one): ☐ FQHC ☐ IHS / HCFA MOA ☐ FEE FOR SERVICE	**Indicate governance structure from choices below:** ☐ Community Nonprofit Board as filed with Secretary of State / Office of Attorney General ☐ Tribally Authorized Charter for Health Program ☐ Tribal Council Self Governance

The undersigned hereby affirms he/she is a duly authorized officer of the Corporation and that the statements contained in this document are true and complete to the best of his/her knowledge.

CHAIRPERSON *(Please Type)*

SIGNATURE **DATE**

EXECUTIVE DIRECTOR *(Please Type)*

SIGNATURE **DATE**

FISCAL OFFICER *(Please Type)*

SIGNATURE **DATE**

Clinic Site Information Form

List the names of reservations or rancherias in the service area and indicate contracting status (attach additional page if necessary):

Reservation / Rancheria (List)	Included in Clinic Service Population (Yes or No)	Administers Own Contract Service Funds (Yes or No)

MAIN CLINIC SITE AND ADDRESS		Located on Reservation / Rancheria ☐ Yes ☐ No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐ Yes ☐ No	Medi-Cal certified: ☐ Yes ☐ No
Office of Statewide Health Planning and Development (OSHPD) Number (if applicable):			
Services Provided:			

Include additional pages if needed to complete the information below on all satellite clinics.

Additional clinic site and address:		Located on Reservation / Rancheria ☐ Yes ☐ No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐ Yes ☐ No	Medi-Cal certified: ☐ Yes ☐ No
OSHPD Number (if applicable):			
Services Provided:			

Clinic Site Information Form Continued

Additional clinic site and address:		Located on Reservation / Rancheria ☐ Yes ☐ No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐ Yes ☐ No	Medi-Cal certified: ☐ Yes ☐ No
OSHPD Number (if applicable):			
Services Provided:			

Additional clinic site and address:		Located on Reservation / Rancheria ☐ Yes ☐ No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐ Yes ☐ No	Medi-Cal certified: ☐ Yes ☐ No
OSHPD Number (if applicable):			
Services Provided:			

Additional clinic site and address:		Located on Reservation / Rancheria ☐ Yes ☐ No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐ Yes ☐ No	Medi-Cal certified: ☐ Yes ☐ No
OSHPD Number (if applicable):			
Services Provided:			

Medi-Cal Provider Status Form

Agency Name:	
Billing Authorization (Attach additional pages if needed) Indicate the clinic provider number for EACH service site certified for Medi-Cal and/or Denti-Cal billing.	
NPI Number(s):	**Site**
NPI Number	Service Site
NPI Number	Service Site
NPI Number	Service Site
Denti-Cal Clinic Provider Number(s):	
NPI Number	Service Site
NPI Number	Service Site
NPI Number	Service Site
If the program is billing the physician's and/or dentist's provider number, complete the information below. For each provider listed below: submit a copy of the written agreement which states that any income derived from billing under the physician / dentist number is clinic income.	
Provider Number	Provider Name and Title
Provider Number	Provider Name and Title
Provider Number	Provider Name and Title

Licensed Personnel Information Form

List of Licensed Health Personnel
(License must be current on date of submission. Attach additional pages if needed)

Name and Title	Type of License	License Number	Expiration Date

Program Narrative Form

Include a project narrative that describes the following:

1. Major accomplishments since July 1, 2008.

2. List the five leading reasons for clinic visits (i.e. Diabetes, Dental, etc.)

   1.
   2.
   3.
   4.
   5.

Certification of Terms and Conditions of Advance Payment

In submitting this application I certify that I am aware of the Terms and Conditions for approval of advance payments for Fiscal Year (FY) 2009-2010. I understand that advance payments will be deducted from the first semiannual prospective payment which will be available upon execution of FY 2009-2010 grants. The grantee shall repay the full amount of any outstanding advance if the grant is not fully approved.

I understand that advance payments are contingent upon the following conditions:

1. The FY 2009-2010 State Budget Act must be passed.
2. The grantee must have submitted all of the following fiscal items in the correct format:
    a. Payment Request Letter (PRL) for up to 50% of the FY 2008-2009 grant award due July 2007
    b. Payment Request Letter (PRL) for up to 40% of the FY 2008-2009 grant award due January 2009,
    c. Budget Expenditure Report (BER) covering expenditures from January 2009-April 2009,
    d. PRL for 10% of the FY 2008-2009 grant award or remaining funds due June 2009,
    e. Annual Budget Reconciliation form due June 2009.
3. The grantee must have submitted all monthly reports in the approved format through May 2009.
4. The grantee must have submitted the required independent audit report referenced in Exhibit "A" of the FY 2006-2007 grant.
5. The corporation must be in good standing with the Secretary of State.

CHAIRPERSON *(Please Type)*

SIGNATURE **DATE**

EXECUTIVE DIRECTOR *(Please Type)*

SIGNATURE **DATE**

FISCAL OFFICER *(Please Type)*

SIGNATURE **DATE**

AUTHORIZATION TO BIND CORPORATION

AND PAYMENT REQUEST APPROVAL FORM

The Board of Directors of the _____

in a duly executed meeting held on _____ and where a quorum was present, resolved to authorize:

Signature: _____ **Date:** _____

Name: _____ Title: _____
(Type/Print)

Signature: _____ **Date:** _____

Name: _____ Title: _____
(Type/Print)

Signature: _____ **Date:** _____

Name: _____ Title: _____
(Type/Print)

to negotiate and sign any State Indian Health Program (IHP) grant and any payment requests that may result. The undersigned hereby affirms he/she is a duly authorized officer of the Corporation and that the statements contained in this document are true and complete to the best of his/her knowledge. The undersigned further affirms that the applicant accepts, as a condition of the grant, the obligation to comply with the applicable State and Federal requirements, policies, standards and regulations. The undersigned further affirms that the funds shall be used to deliver primary medical, dental, and community health services to program beneficiaries. The undersigned recognizes that this is a public document and is open to public inspection.

Signature: _____ **Date:** _____
(Corporate Officer's Signature)

Name: _____ Title: _____
(Type/Print)

Form Completion Instructions: At least two persons must be authorized to sign payment requests. A current Authorization to Bind form must be kept on file with the IHP. A copy of this form and the IHP address may be found at http://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx.

When changes to this authorization occur please submit an updated Authorization to Bind form within ten (10) working days.

All signatures must be in blue ink.

State of California – Health and Human Services Agency
Department of Health Care Services

Primary and Rural Health Division
Indian Health Program (IHP)

Board of Directors Information Form

(Please use additional pages if necessary)

Name of Board Member:	
Elective Position:	
County of Residence:	
Employer:	
Tribal Affiliation:	
Term (Beginning and Expiration Dates):	

Name of Board Member:	
Elective Position:	
County of Residence:	
Employer:	
Tribal Affiliation:	
Term (Beginning and Expiration Dates):	

Name of Board Member:	
Elective Position:	
County of Residence:	
Employer:	
Tribal Affiliation:	
Term (Beginning and Expiration Dates):	

Name of Board Member:	
Elective Position:	
County of Residence:	
Employer:	
Tribal Affiliation:	
Term (Beginning and Expiration Dates):	

Name of Board Member:	
Elective Position:	
County of Residence:	
Employer:	
Tribal Affiliation:	
Term (Beginning and Expiration Dates):	

(Applicant)

TABLE 1
SUMMARY OF
CURRENT BUDGET FROM ALL SOURCES
(As of May 2009)

FUNDING SOURCE (Include Medi-Cal and Other Third Party Revenues)	SUBTOTALS			TOTALS
	Personnel	Operating Expenses	Consultants	
SUMMARY TOTALS	$	$	$	$

Grand Total

(Applicant)

TABLE 2

CURRENT PERSONNEL LINE ITEM BUDGET FROM ALL SOURCES

(As of May 2009)

PERSONNEL	SOURCE OF FUNDS				TOTALS
	State (Specify program)	Federal	County	Third Party (Specify source)	
TOTAL SALARIES	$	$	$	$	$

Grand Total

Table 3 - Total Clinic Projected Revenues and Expenses

(Applicant)

EXPENSES	Fiscal Year 2008-2009
Personnel	
Operating Expenses	
Capital Expenditures	
Other Expenses	
Indirect Costs	
TOTAL EXPENSES	
REVENUES	
Patient Revenue:	
Medicare	
Medi-Cal / Fee for Service	
Medi-Cal / Managed Care	
Healthy Families Program	
Private Insurance	
Patient Pay	
Other	
Institutional Support:	
Federal	
State	
County	
Private	
Donations / Contributions	
Other	
TOTAL REVENUES	

_____

(Applicant)

TABLE 4 - PAGE 1
Proposed IHP Budget: FISCAL YEAR 2009-2010

PERSONNEL

PAY PERIOD (CHECK ONE) ❑ Biweekly (26) ❑ Semimonthly (24) ❑ Monthly (12)

POSITION TITLE	(A) FTE Salary Per Pay Period	(B) No. of Pay Periods	(C) % of FTE	(D) % Paid by this Grant	(E) Amount Requested A x B x C x D
				TOTAL SALARIES	

FRINGE BENEFITS _____ Percent of Personnel Costs used [average])

FICA @ _____ %

SUI @ _____ %

WC @ _____ %

TOTAL FRINGE BENEFITS $

TOTAL Personnel Services

OPERATING EXPENSES

Audit	
Communications	
General Expenses	
Insurance	
Janitorial and Maintenance Services	
Rent (_____sq. ft. x $_____sq. ft. / mo. = $_____/ mo. X _____mos. X _____% / State Share)	
Technical Supplies	
Traditional Health / Medicine	
Travel	
Utilities	
TOTAL Operating Expenses	$

_____

(Applicant)

TABLE 4 - Continued
Proposed IHP Budget: FISCAL YEAR 2009-2010

CAPITAL EXPENDITURES

Equipment (List detail below)

(A) Quantity	Description	(B) Unit Cost	(A x B) TOTAL COST
		TOTAL Capital Expenditures	**$**

OTHER COSTS

Computer Hardware	
Computer Software	
Consulting and Professional Services Total (see breakdown below)	

Subcontractor's Name and Title	Rate of Dollars Per Hour	Total Subcontract Amount

Staff Training and Continuing Education	
TOTAL Other Costs	**$**

INDIRECT COSTS

Indirect Cost: _____ % of

TOTAL Indirect Costs	**$**
TOTAL BUDGET	**$**
TOTAL percent of IHP budget directed to main clinic expenses	

Exhibits

EXHIBIT 1

IHP Provider Productivity Standards

IHP grantee Scopes Of Work for medical, dental, and community health services are determined through the application of the IHP Provider Productivity Formula The Provider Productivity Formula is based on the Estimated Staffing Pattern for Fiscal Year (FY) 2008-2009 distributed to clinics annually.

The following minimal standards represent those for a full-time equivalent (FTE) staff person.

Medical

Indian health clinic Physicians are expected to have at least 2,289 visits annually. Medical Directors may have less visits expected based on their administrative responsibilities.

Physician Assistants and Family Nurse Practitioners are expected to have at least 1,526 visits annually.

Dental

Dentists are expected to have at least 1,091 visits annually.

Dental Hygienists are expected to have at least 714 visits annually.

Community Health Services

Community Health Representatives (CHRs) are expected to have at least 1,000 contacts annually.

EXHIBIT 2

Clinic Funding via the Indian Health Program (IHP) Allocation Formula

IHP primary care funds are distributed in compliance with Health and Safety Code Section 124585 (d) and Title 17, Chapter 3.1, Section 1532, according to a need and performance driven formula that is comprised of five weighted factors to grantees that meet the minimal eligibility requirements and were grantees in the previous fiscal year.

Factor 1:
Systems Evaluation (SE) (46%): This factor is based on the scored biennial, on-site evaluation of the clinic's Medical, Dental, Community Health Services and Board / Administrative / Fiscal systems. Individual clinic scores are used to determine funding amounts for this component. The SE is conducted using rigorous protocols allowing for clinic preparation time and standardized evaluation processes. The SE review documents are based on the four IHP guidelines: 1) Board, Administration, and Fiscal, 2) Medical, 3) Dental, and 4) Community Health Services. This factor of the IHP clinic allocation formula addresses the demonstrated ability of a clinic to carry out proposed services and that the clinic has adequate staff to provide the services

Factor 2:
Foundational Criteria (22%): A clinic eligible for IHP funding must provide at least two of the following three components: Medical, Dental and Community Health Services (CHS). Funds are distributed proportionately according to the service components that a clinic provides. This factor of the IHP clinic allocation formula addresses the ability of the program to comply with the statewide plan for Indian health services and existing priorities for services

Factor 3:
Grant Objectives (15%): This factor measures how well grantees have met the numerical service objectives in their grants. Data to measure achievement of grant objectives are obtained from the number of **visits** reported on the Progress Reports submitted by the clinic. This factor of the IHP clinic allocation formula addresses the number of individuals to be served and the demonstrated ability of the clinic to carry out the proposed services.

Factor 4:
Population Service Index (15%): Funding for this factor is based on the number of **individual** AI/AN patients actually served during the calendar year. Data to measure this factor are also obtained from the progress reports submitted by the clinic. A per capita rate based on the unduplicated patients served by each grantee determines the funds awarded for this factor. This factor of the IHP clinic allocation formula also addresses the number of individuals to be served.

Factor 5:
Target Population (2%): This final factor recognizes the size of the AI/AN population in a clinic's service area. The population figures used are from estimates of the service area population prepared by the IHS using the U.S.

EXHIBIT 2

Census Bureau. A per capita figure determines the funds awarded for this factor. This factor of the IHP clinic allocation formula also addresses the number of individuals to be served.